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**Registration Paperwork**

Forms to be completed:

* Patient Registration Form
* Patient Medical History Form
* Information for New Patients Form
* Telehealth Consent Form

**Instructions**

1. Print and complete Patient Registration Form, Patient Medical History Form, Information for New Patients Form, Telehealth Consent Form
2. Sign all forms
3. Bring completed and signed forms to your first therapy appointment along with your photo id and insurance card(s)

**If you have any questions about these forms, please contact us at any time.**

**HARRISON PHYSICAL THERAPY**

**REGISTRATION FORM for PATIENT INFORMATION**

FIRST NAME MI LAST NAME HOME PHONE CELL PHONE

STREET ADDRESS CITY STATE ZIP

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

EMAIL ADDRESS

MARRIED SINGLE STUDENT RETIRED WORKING

MALE

FEMALE DIVORCED WIDOWED

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT HARRISON PHYSICAL THERAPY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN (What location do you see the doctor?) PRIMARY PHYSICIAN EMERGENCY CONTACT NAME & PHONE #

**PATIENT PRIVACY**

**►May we leave phone messages regarding your appointments or other information regarding your care?**  YES NO

**► Someone other than yourself, that we may discuss your condition with, and can make decisions on your behalf regarding your physical therapytreatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### ALL PATIENTS

**I AUTHORIZE PAYMENT OF MEDICARE &/or INSURANCE BENEFITS BE MADE ON MY BEHALF DIRECTLY TO HARRISON PHYSICAL THERAPY FOR ANY SERVICES FURNISHED TO ME BY EMPLOYED LICENSED PHYSICAL THERAPIST. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION ABOUT ME NEEDED TO DETERMINE THE PAYMENTS FOR RELATED SERVICES.**

**I VERIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION TO THE BEST OF MY ABILITY.**

**x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE (IF THE PATIENT IS A MINOR, A PARENT SIGNATURE IS REQUIRED)**

**INJURY INFORMATION**

CHECK THE CONDITION THAT APPLIES: AILMENT INJURY ACCIDENT SURGERY

ONSET DATE OF INJURY OR SURGERY DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE OF ACCIDENT / INJURY: WORK PLAY HOME AUTO

DESCRIBE HOW ACCIDENT / INJURY HAPPENED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### WORKERS’ COMPENSATION PATIENTS ONLY

WORKERS’ COMPENSATION CLAIM # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ORIGINAL DATE OF ACCIDENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S NAME & ADDRESS AT TIME OF ACCIDENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IS THIS COMPANY SELF INSURED? YES NO

NAME OF EMPLOYEE WHO HANDLES WORKERS’ COMP. CLAIMS FOR THIS COMPANY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORKERS’ COMPENSATION NOTE**  **- If your claim goes to a hearing or pending status, you will be responsible for payment**

**HARRISON PHYSICAL THERAPY**

**PATIENT MEDICAL HISTORY**

**Heart Disease: \_\_\_\_\_ YES \_\_\_\_\_ NO**

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stroke: \_\_\_\_\_ YES \_\_\_\_\_ NO**

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**High Blood Pressure: \_\_\_\_\_ YES \_\_\_\_\_ NO**

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies: \_\_\_\_\_ YES \_\_\_\_\_ NO**

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Epileptic/Seizures: \_\_\_\_\_ YES \_\_\_\_\_ NO**

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Medications/Supplements/Hormones:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgeries: \_\_\_\_\_ YES \_\_\_\_\_ NO**

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancer: \_\_\_\_\_ YES \_\_\_\_\_ NO**

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetic: \_\_\_\_\_ YES \_\_\_\_\_ NO**

**Phlebitis: \_\_\_\_\_ YES \_\_\_\_\_ NO**

***Female Patients - At present time, are you*:**

**Pregnant: \_\_\_\_\_ YES \_\_\_\_\_ NO**

**Menstruating: \_\_\_\_\_ YES \_\_\_\_\_ NO**

**I.U.D.: \_\_\_\_\_ YES \_\_\_\_\_ NO**

Patient Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous illness or injuries related to present problem? Give dates:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional medical information: (feel free to attach your own list)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **IF AT ANYTIME** you need to discuss information in confidence with our staff regarding your condition, health information or financial information; a private area can be made available. Please inform your therapist.
2. **IF AT ANYTIME** you wish your curtain to be pulled during treatment, please inform a Harrison Physical Therapy staff member.
3. Your therapy may include the opportunity to exercise in our open gym area. **IF AT ANYTIME** you desire not to exercise in our open gym, please inform a Harrison Physical Therapy staff member.

I have read the above statements and completed my medical history to the best of my ability and **I give my consent for physical therapy evaluation and treatment at HARRISON PHYSICAL THERAPY.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature (If the patient is a minor, a parent must sign.)

**HARRISON PHYSICAL THERAPY**

**INFORMATION FOR NEW PATIENTS**

* **Verification of Benefits:** We will be glad to contact your Insurance Company to verify that this is a covered service, and we ask that you do the same so that you are aware of your physical therapy benefits.
* **Consent for Services**: I understand that I am financially responsible for all charges whether or not paid or allowed by insurance. As a condition of your treatment by this office, note that payment is due at the time of service. Patients with insurance will be asked to pay their estimated portion at the time of service. As a courtesy, our office will submit claims to your medical insurance company on your behalf. You are responsible for notifying the office about changes to your insurance policy.
* **Your signature** below gives Harrison Physical Therapy permission to release to your insurance company all information necessary to secure the payment of benefits. It also serves as authorization for your insurance company to pay this office for all benefits otherwise payable to you for services rendered and to use this signature on all insurance submissions.
* **HIPAA**: Notice of our HIPAA Privacy Policy is clearly posted in our reception room as mandated by law. Your signature on this form is your acknowledgment of that. If you would like a written copy of our specific HIPAA policies, please ask an administration member of our team.
* **Cancellation Fee:** If cancellation of an appointment is necessary, please call 24 hours ahead of time. If you DO NOT give 24 hours’ notice, you will be charged $50, which is not covered by insurance. The fee will be assessed for late cancelled and broken appointments. You will need to pay the $50 prior to being seen again for physical therapy. If you miss 3 of your scheduled physical therapy visits, *we reserve the right to* **cancel all remaining scheduled appointments** *for the duration of your physical therapy* treatment.
* **Litigation:** I am aware that if there is litigation pending, and if I have medical insurance, Harrison Physical Therapy will file claims with my medical insurance carrier. If I do *not* have medical insurance, I am responsible for payment of my bill with **regular monthly** payments and that Harrison Physical Therapy will not wait until the case is settled for payment.
* **No Insurance:** You must plan for payment of your bills prior to beginning physical therapy. ***Regular payments are required.***
* **Workers’ Compensation:** Patient should be aware that they are still responsible for payment if Workers’ Compensation rejects the claim. **If claims go to a hearing or pending status, we will file you your medical insurance or regular payments will be required.**
* **Auto Insurance:** When auto insurance is the payor of a claim due to injury/car accident (when NO litigation is involved), we will wait a reasonable time for the auto insurance to pay. If no payments are made in 60 days, we will bill you, the patient. You may arrange a payment plan with the billing secretary.
* **Clothing:** For patients having physical therapy on their knees, legs, back and ankles, we ask that you bring/wear shorts and tennis shoes. If you are coming in for a shoulder injury, we suggest that you wear a t-shirt or tank top. If you will be doing exercises during your treatment, please dress so that you will be able to move freely.

Signature Of Patient, Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Patients Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HARRISON PHYSICAL THERAPY**

**TELEHEALTH CONSENT FORM**

**INTRODUCTION:** Telehealth involves the use of audio, video or other electronic communications to interact with you, consult your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telehealth consultation, details of your medical history and personal health information may be discussed with you or other health professionals using interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

**ANTICIPATED BENEFITS:**

* Improved access to medical care by enabling a patient to remain in his/her location while the therapist may provide care from a distant site
* More efficient medical evaluation and management
* Obtaining expertise of a distant specialist

**POSSIBLE RISKS:** As with any therapeutic care, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

* In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision-making by the therapist
* Delays in medical evaluation/treatment could occur due to deficiencies or failures of the electronic equipment
* In rare instances, security protocols could fail, causing a breach of privacy of personal medical information

**BY SIGNING this form, I understand the Following:**

1. I understand that I may expect the anticipated benefits from the use of the telehealth in my care, but that no end results can be guaranteed.
2. I understand that the laws that protect the privacy and security of health information apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my authorization.
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time.
4. I understand that I have the right to inspect all information obtained and recorded during a telehealth interaction and may receive copies of this information.
5. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My therapist has explained the alternative to my satisfaction.
6. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.
7. I understand that it is my duty to inform my therapist of electronic interactions regarding my care that I may have with other healthcare providers.
8. I understand that if my medical insurance coverage is not enough to satisfy the medical service charges in full, I may be fully responsible for payment.

**PATIENT CONSENT to the Use of Telehealth:**

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my therapy care.

**PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature (If the patient is a minor, a parent must sign.)